



*International Association of Fire Fighters  
AFL-CIO, CLC*

**The Critical Need for  
Public Prehospital Care in Canada:  
*Utilizing the Efficiencies  
of a Fire-Based EMS System***

*Submission to  
The Romanow Commission  
on the Future of Health Care  
in Canada*

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## **1. Introduction**

On behalf 17,000 professional fire fighters and emergency medical personnel in Canada, and the citizens whose lives they protect, the International Association of Fire Fighters welcomes the opportunity to share our insights and expertise on a critically important issue to Canadians – the future of our health care system.

Whether they are the fire fighters in cities like Toronto or Calgary, dual-trained fire fighter paramedics in cities like Red Deer and Brandon, all 17,000 Canadian IAFF members are first responders at medical calls and accidents, and as such they are front-line medical personnel. They are health care workers who play a critically-important role in Canada's healthcare system, specifically, in the vital area of prehospital care.

The term prehospital care refers generally to situations such as accidents or sudden illnesses that require immediate emergency intervention and patient transport to a medical facility. The prehospital care system in Canada takes a variety of forms, from province to province and even from community to community. All of these service types can be described under the banner of Emergency Medical Services (EMS). They all operate with the same objective: a fast and highly skilled emergency response in the critical first few minutes following a medical emergency - a heart attack, for example, or a car accident. The speed of the response capability and the training of its EMS personnel in a given community are directly linked to patient outcomes in that community. Quality prehospital care is a critically important element of the overall quality of health care services at a local level, and on a national scale.

But who is providing that service? What factors went into the system design that is utilized in a particular city? Was the system designed to utilize the best available resources to improve patient outcome, or did politics and rhetoric influence the decision? Were all of the options studied?

Most importantly, was the system designed to save lives, or save money? Did the contract go to the those who are best positioned to deliver fast and skilled prehospital care, or did it go to the lowest bidder?

Universal health care is sacred to Canadians. We treasure a public system that is publicly funded, publicly accessible and publicly delivered – including everything from a simple visit to the doctor to the most advanced medical care available. Prehospital care is an important part of that care, and as such, should be publicly delivered in order to provide the best patient outcome.

In Canada there exists a significant public sector force of trained professionals who are in the best position to provide fast and effective emergency medical services: professional fire fighters. They are stationed across hundreds of Canadian cities, four minutes from any emergency call in an urban setting. They are already utilized as first responders in

medical emergencies. But their true potential in the realm of EMS remains largely untapped, for the want of additional training and political will. Bright now, fire fighters are uniquely positioned to play a role in any EMS system design, to the benefit of the communities they serve.

In a handful of Canadian cities, dual-trained fire fighters successfully provide complete EMS services, including patient transport. They are an excellent model of effective and publicly-funded prehospital care that maximizes cost outlay through the use of existing resources.

## **2. Universal Health Care: a Legacy to Protect**

There is nothing more important to any individual than their state of physical health. Without good health, we have nothing.

It is unavoidable that a given individual will suffer from illness or injury through their lifetime. We are fortunate to live in a day and age when available medical technologies allow for the treatment and, hopefully, recovery. Canadians are additionally fortunate to be served by a medical care system that is the envy of many countries. It is a fundamental principle of our health care system that care is granted universally to all Canadians, through a publicly funded system. Our access to medical services is based on need, not on socioeconomic status, religion, political affiliation, level of education, race, gender or any other factor.

What started as a revolutionary idea in the prairies; condemned at first by many of Saskatchewan's doctors and citizens alike, has grown into a sacred national treasure. Our universal health care system has helped define us as Canadians over the past half century.

This world-renowned health care system did not invent itself. It came about as the result of an extraordinary vision, formidable will and remarkable perseverance. It was not built overnight, but developed over the years; adapting where necessary but, in the past, always with the principles of universality and public funding at the forefront.

## **3. Today's Threat: Privatization**

There is a great deal of concern about the sustainability of the current public funding model. With changes in the dynamics of the federal and provincial relationship, changes in global economies and changes in medical technologies, many argue that the need for adaptation has never been so pronounced. However, to use what should be a transitional period to sell our public healthcare system to the highest bidder in a panic would be a travesty of the highest degree.

Private health care providers already have their foot in the door in Canada. They preyed upon public and government fears over debt load and public finances in the past decade to wrest health care services, such as EMS, away from the public sector, for the sole purpose of reaping profits for their shareholders. These corporations, with the help of

their political allies, will use the current debate to attempt to increase their footing in Canada's health care system, changing it from a fundamental public service into an industry.

The IAFF agrees that money is an important consideration in the delivery of health care. But it cannot be the driving force when lives are at stake.

Much can be learned about private ambulance operators by examining what happened in the United States in the 1990s. Private corporations saw the potential for huge profits in the ambulance industry and jumped headlong into the equation. But when stock prices fell and profits dried up, private operators abandoned contracts in Philadelphia, for example, and several Massachusetts cities. Further, private operators lost contracts in Hartford, CT, Buena Park, CA, Fort Wayne, IN, Colorado Springs, CO and several Texas cities because of poor response times and other performance problems. These cases illustrate that the private operators in the U.S. were not in it for the long haul. They were not committed to their communities. It also illustrated that profit cannot be the driving force behind the provision of emergency medical services.

#### **4. Prehospital Care – A Critical Link**

The link between EMS response time, the level of EMS delivered and patient outcome is best described by the results of Phase II of the Ontario Prehospital Advanced Life Support (OPALS) Study. OPALS applied a controlled study of cardiac arrest survival rates in the 36 months before (Phase I) and 12 months after (Phase II) the implementation of a rapid defibrillation program in an urban centre. The study includes data from 19 Ontario municipalities ranging in size from 16,000 to 750,000.

OPALS Phase II results showed that a community can more than double its cardiac arrest survival rate, and inexpensively so, if a defibrillator unit can be on scene within five minutes of the call 90 per cent of the time. Full-time fire departments across Ontario typically have a response time of four minutes.

In August 2001, the National Fire Protection Association (NFPA) issued Standard 1710, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations and Special Operations to the Public by Career Fire Departments*.

This internationally-recognized standard requires all career fire departments to provide at least a Basic Life Support (BLS) level of EMS, arriving within a four-minute response timeframe for 90 per cent of all incidents. If an Advanced Life Support (ALS) model is used, an eight-minute response time must be met for 90 per cent of incidents. These response times are based on scientific studies which showed conclusively that first responder units with cardiac defibrillators arriving within eight minutes led to a significant increase in cardiac arrest survival rates.

#### **5. Prehospital Care in Canada: A Patchwork**

As regional EMS needs may differ based on local resources, geography, legislative factors and local wishes, no single EMS system can be suitably applied to any given Canadian jurisdiction. But at the same time, professional fire fighters are positioned to play an effective role in every kind of EMS system design, that role depending on the above factors.

The impetus for the development of universally-accessible prehospital care in Canada is governed by the *Canada Health Act* and its guiding principles. Since each province's EMS system was designed with respect to local needs and resources, no two provincial EMS systems are organized in exactly the same way.

There are many issues involved in the overall discussion of EMS delivery in Canada, including applicable provincial legislation, systems of dispatch and local political considerations. The combination of these issues will impact the ability – or inability – of professional fire fighters to gain a greater role in the delivery of EMS, provincially and locally as well. It's important to note that while issues like cost will always come up during this debate, the bottom line when it comes to EMS must always be about patient outcome and not profits. In that regard, the merits of the fire service are well-documented.

It's fair to say there is a great deal of rhetoric in the debate over who is best positioned to provide EMS services in Canada. Unfortunately, a lot of that rhetoric is directed toward the fire service by parties that have a vested interest in keeping the fire service out of EMS.

In some provinces, like British Columbia, where legislation states that you have to be a member of a paramedic group to receive EMS training, there are particular roadblocks facing the development of fire-based EMS. In other provinces, such as neighbouring Alberta, a system of cross-trained, dual-role "FireMedics," as they are known, perform both fire suppression and EMS duties successfully in several communities. In other provinces, like Ontario, recent legislative changes in responsibility for the service from the provincial to the local level have sparked new and significant levels of debate over EMS delivery. The entire system is in a state of flux as existing providers, private operators and the fire service advocate for their roles in redesigned local systems.

The skills practised by an individual EMT will vary from province to province, even from city to city. The terminology for providers with similar levels of training differs. For example, an "Emergency Medical Responder" in Alberta refers to a provider who has participated in a 120-hour training program and who can provide skills similar to an EMT-Basic in the U.S. But in Manitoba, an Emergency Medical Responder is required to take only a 90-hour course and is limited to skills similar to a Certified First Responder in the U.S.

In some provinces, all EMS providers are called "paramedics," and are differentiated only by certain designated levels, such as EMA-I Paramedic for first responders and EMS-II Paramedic for personnel providing care similar to full EMT Paramedics.

Training levels and provider terminology are not the only areas in which the provinces differ. In general, EMS and ambulance transportation are considered essential public health services. How those components are funded and managed has been left for provinces to decide. Ambulance services in Nova Scotia, for example, are provincially funded with the province owning the vehicles and equipment. In contrast, similar services in Alberta and Saskatchewan are independently operated and funded through billing. The vehicles and equipment are owned by the operators.

## **6. Attributes of a Fire-Based Prehospital Care System**

Virtually all communities across Canada have some form of emergency medical service (EMS) system. To a large extent individual communities have the ability to choose the type of EMS system and its components, according to the community's needs and wishes. System designs include the following:

- Fire-based EMS using cross-trained/dual role fire fighter-paramedics
- Fire-based system using EMS employees who are not cross-trained as fire suppression personnel
- Public single-role EMS system separate from the fire department (known as third service)
- Combined system using the fire department as emergency response and a private provider for transport
- A private provider system that is separate from the fire department

For any one community, the components of the system and the level of the service must be tailored to the needs and wants of that community. That is to say that no single system can be applied every community successfully. While an EMS system is unique to the jurisdiction, the industry recognizes a standard approach to the assessing local needs and meeting those needs with specific service elements.

Prehospital EMS systems are composed of the personnel, vehicles, equipment and facilities used to deliver medical care to individuals with unanticipated and immediate medical needs arising outside a hospital. Key services of EMS systems include public access through a coordinated communications system, prehospital safety and EMS response and transportation. In many communities, fire departments are the primary providers of EMS. In some communities, however, fire departments have only recently taken on the role of patient transportation. This has led those who are not familiar with EMS to think that this is something new for the fire service. Yet from the beginning, fire departments in Canada and the U.S. have played an integral role in the development of prehospital EMS. Dual role fire fighters have not only provided time-critical response and transport, but have also developed and tested much of the equipment and procedures used in EMS today.

Response time has been critical in treating traumatic injuries as well as illnesses, and fire departments in North America have been providing timely responses since the 1930s,

when fire fighters in major cities began providing first aid. As new lifesaving techniques were developed, fire fighters in several U.S. cities began to implement those techniques in the field. Such advances included oxygen delivery systems, cardiopulmonary resuscitation, and portable cardiac defibrillators.

As communities evaluate their emergency medical care needs, they may focus exclusively on patient transportation issues. Most research on patient survival, however, has demonstrated that rapid, on-scene medical intervention, not just transport, produces the best patient outcomes.

The fire department is best positioned to deliver time-critical response and effective patient care. In Canadian cities, fire fighters are positioned for four-minute response coverage throughout their communities. Fire fighters who act as first responders are commonly first on the scene, providing medical attention until an ambulance arrives.

As individual communities examine new models for EMS services, it only makes sense to examine expanding the role of fire fighters, through additional training and resources. The personnel are already there, and they are already arriving at the scene of medical emergencies. Taking advantage of the existing infrastructure of the fire department is an achievable means of effecting benchmark EMS response times of four minutes, without the cost of adding a separate and parallel structure of EMS response.

## **7. Emergency Dispatch: An Area of Concern**

The issue of emergency dispatch is one that is critical to the overall discussion of emergency response, as the design of a specific dispatch system as it varies from province to province and even city to city affects emergency response times and ultimately the ability of the fire service to advocate its role in EMS fairly.

Specifically, fire and ambulance response times to medical calls are too often compared incorrectly because in a number of dispatch systems, fire is dispatched after ambulance, sometimes several minutes later. Because of this, fire may arrive at a medical call later than ambulance even though the fire station was closer to the scene. The problem results when response times for a service are measured from the time of the initial 911 call, and not the time when the fire service, for example, was actually dispatched.

The scenario of delayed fire dispatch is particularly true in British Columbia and Ontario, where various factors not only affect the fire service's ability to advocate its role in EMS, but more importantly result in a potential impact on public safety.

## **8. Conclusion**

Few people would suggest that Canada's health care system should not adapt in accordance with the new realities of emerging medical technologies or changing public economies. A review of the way public health care is delivered in Canada is entirely

appropriate. But we must not allow it to be used to facilitate further privatization in any element of Canada's universal health care system, including prehospital care.

Canada's career fire departments, and the trained professionals who staff them, constitute a wealth of untapped potential in the realm of EMS and prehospital care. Fire fighters are positioned to play an integral role in any kind of EMS system, providing skilled patient care and benchmark response times.

Again, the International Association of Fire Fighters is appreciative of the opportunity to submit comment on this critically important issue, the future of health care in Canada. We look forward to presenting our views to Commission in person during 2002.

Respectfully submitted,

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